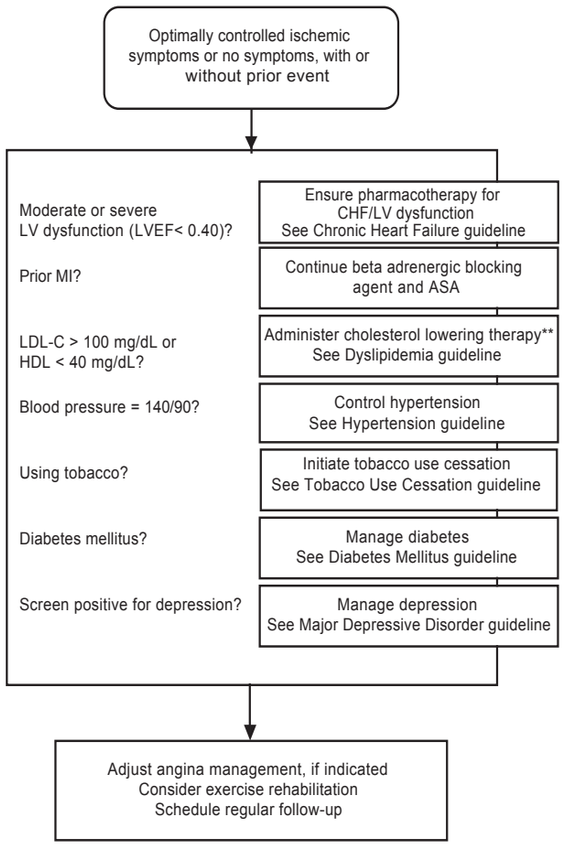
Secondary Prevention

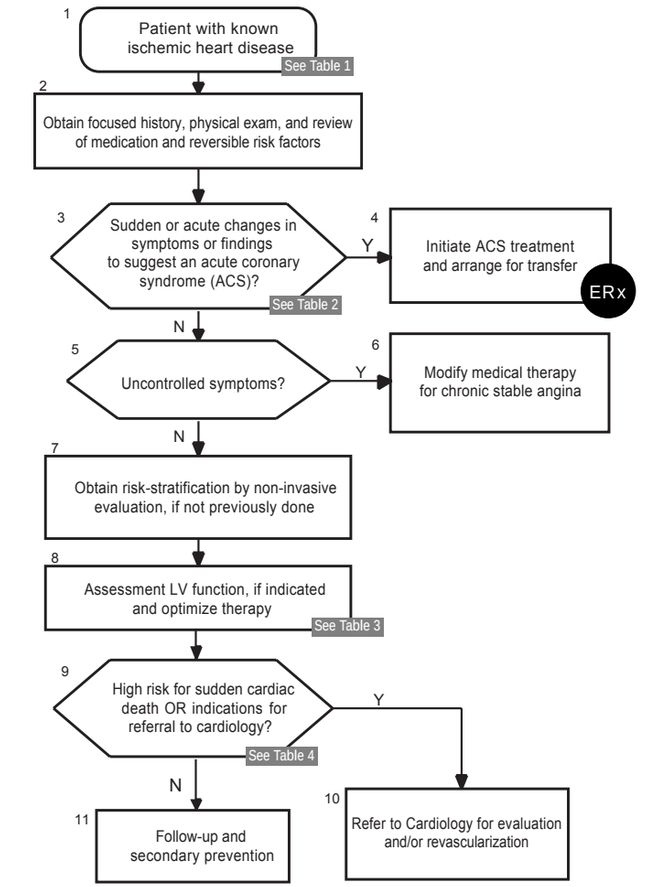


** For LDL-C ≥100 mg/dL: Initiate diet and exercise and consider drugs
For LDL-C ≥130 mg/dL: Initiate diet, exercise and statin therapy
For LDL-C <130 & HDL <40 mg/dL: Initiate gemfibrozil

For medication information see document,

PHARMACOTHERAPY FOR CARDIOVASCULAR DISEASES

VA/DoD Clinical Practice Guideline Management of Ischemic Heart Disease (IHD) - Module G Medical Follow-Up & Secondary Prevention Pocket Guide



VA access to full guideline: http://www.oqp.med.va.gov/cpg/cpg.htm
DoD access to full guideline: http://www.QMO.amedd.army.mil
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NATIONAL CPG COUNCIL

Table 1: DIAGNOSIS OF CORONARY ARTERY DISEASE (CAD)

- Prior myocardial infarction (MI) and/or pathologic Q-waves on the resting electrocardiogram (ECG)
- Typical stable angina in males > age 50
- Cardiac stress test showing evidence of myocardial ischemia
- Left ventricular (LV) segmental wall motion abnormality by angiography or cardiac ultrasound
- Silent ischemia, defined as reversible ST-segment depression by ambulatory ECG monitoring
- Significant obstructive CAD by angiography
- Prior coronary revascularization (percutaneous coronary intervention or coronary artery bypass graft surgery)

Table 2: Symptoms That May Represent Ischemia or MI

- Chest pain, discomfort, pressure, tightness, or heaviness (defined as at least a one-class increase Canadian Cardiovascular Society angina classification)
- Radiating pain to the neck, jaw, arms, shoulders, or upper back
- Unexplained or persistent shortness of breath
- Unexplained epigastric pain
- Unexplained indigestion, nausea, or vomiting
- Unexplained diaphoresis
- Unexplained weakness, dizziness, or loss of consciousness

For Diagnosis of ACS See the Core Pocket Guide

Symptom Characteristics Suggesting Non-Cardiac Pain

- Pleuritic pain (i.e., sharp or knife-like pain brought on by respiratory movements or cough)
- Primary or sole location of discomfort in the middle or lower abdominal regions
- Pain that may be localized at the tip of one finger, particularly over costochondral junctions or the LV apex
- Pain reproduced with movement or palpation of the chest wall or arms
- Constant pain that lasts for many hours
- Very brief episodes of pain that last a few seconds or less
- Pain that radiates into the lower extremities

ERx Emergency Intervention for Acute Coronary Syndrome

- **Cardiac monitor**
- **O_2**
- **Chew aspirin 160-325 mg**
- **IV access**
- **Obtain lab test (cardiac specific enzymes)**
- **SL-NTG, if no contraindication**
- **12-lead ECG**
- **Adequate analgesia**
- **ACLS intervention, if necessary**
- **Chest X-ray, if available**
- **Arrange transportation**

Table 3: Indications for assessment of LV Function

Symptoms of CHF (e.g., orthopnea or paroxysmal nocturnal dyspnea)
Significant impairments or recent decrement in exercise tolerance, due to dyspnea or fatigue
Physical signs of CHF (e.g., elevated jugular venous pressure, unexplained pulmonary rales, laterally displaced point of maximal impulse, and S3 gallop)
Cardiomegaly on chest x-ray
History of prior MI or pathologic Q-waves on the ECG.

Table 4: Referral to Cardiology

Moderate/severe LV dysfunction
Persistence of CHF symptoms and after initial therapy
Class III or IV angina, despite maximal medical therapy
Patients whose prior results from coronary angiography suggest a possible survival benefit from the use of coronary bypass surgery
Patients without prior coronary angiography, but have Class III-IV angina or heart failure or high-risk results of non-invasive tests.
Patients with high-risk for sudden cardiac death: • History of risk of sudden cardiac death or sustained monomorphic ventricular tachycardia to an electrophysiologist • LVEF<0.40 and nonsustained ventricular tachycardia • LVEF<0.40 and syncope of undetermined etiology

Medical Therapies For Patients With LV Dysfunction

ACE inhibitors improve morbidity and mortality in patients with CHF or low EF
Asymptomatic patients, but with low EF, experience survival benefit from ACE inhibitors
Doses of ACE inhibitors should be equivalent to 20mg enalapril qd to obtain greatest benefit
Beta-blockers should be considered for all patients with NYHA class II or III CHF, and EF<0.40, after stabilization on ACE inhibitors
Addition of spironolactone to ACE inhibitors and diuretics in patients with severe heart failure improves morbidity and mortality
Digoxin use in heart failure (EF<0.45) does not affect mortality, but decreases hospitalization due to heart failure
Diuretics improve symptoms of volume overload